Senate Commerce, Labor and Agriculture Committee 1

Amendment No. 1 to SB3843

Johnson
Signature of Sponsor

AMEND Senate Bill No. 3843* House Bill No. 3832

by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-120(a)(1), is amended by deleting the subdivision in its entirety and substituting instead the following:

(a)(1) Notwithstanding any law, rule, or regulation to the contrary, whenever any policy of insurance issued in this state provides for coverage of health care rendered by a provider covered under title 63, the insured or other persons entitled to benefits under the policy shall be entitled to assign these benefits to the health care provider and such rights must be stated clearly in the policy. Notice of the assignment must be in writing to the insurer in order to be effective; however, such notice can be provided by other means if it is so stated in the policy.

SECTION 2. Tennessee Code Annotated, Section 56-7-120, is amended by adding a new subsection (c) as follows:

(c)(1) For purposes of this subsection a "participating health care facility" shall mean a health care facility that has a current contract provider agreement with the insured's insurer, and a "non-participating facility based physician" shall mean a physician:

(A) To whom a participating health care facility has granted clinical privileges;

(B) Who provides services to patients of the participating health care facility pursuant to those clinical privileges; and

(C) Who does not have a current contract provider agreement with the insured's insurer.

(2) Unless the following conditions setout in this subdivision (c)(2) are satisfied, an insured's assignment of benefits pursuant to subsection (a) may be disregarded by an insurer if the assignment of benefits is to a non-participating facility based physician:

(A) The health care facility provides written notice to the insured that:

(i) Informs the insured that the non-participating facility based physician may not have a current contract provider agreement with the insured's insurer; and

(ii) Informs the insured that he or she may receive a bill for medical services from the non-participating facility based physician for the amount unpaid by the insured's insurer;

(B) The notice required by this subdivision (c)(2)(A) shall be provided to the insured, or the insured's personal representative, prior to when the insured first receives services from the non-participating facility based physician. In circumstances where the insured is receiving emergency medical services or is incapacitated or unconscious at the time of receiving such services, the notice will not be required if the provisions of that notice will be in contravention of the provisions of the federal EMTALA laws, codified in 42 U.S.C. § 1395. The failure of the health care facility to provide the notice required by subdivision (c)(2)(A) shall not give rise to any right of indemnification or private cause of action against the health care facility by any non-participating facility based physician for an insurer's disregard of an insured's assignment of benefits unless the health care facility's failure to provide such notice is due to willful or wanton misconduct of an agent of the health care facility, and

(C) The non-participating facility based physician provides the insured a billing statement that:

(i) Contains an itemized listing of the services and supplies provided along with the dates the services and supplies were provided;

(ii) Contains a conspicuous, plain language explanation that:

(*a*) The non-participating facility based physician does not have a current contract provider agreement with the insured's insurer; and

(*b*) The insurer has paid a rate, as determined by the insurer, that is below the non-participating facility based physician's billed amount;

(iii) Contains a telephone number to call to discuss the billing statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

(iv) Contains a statement that the insured may call to discuss alternative payment arrangements; and

(v) For billing statements that total an amount greater than two hundred dollars ($200), over any applicable copayments, coinsurance or deductibles, states, in plain language, that if the insured finalizes a payment plan agreement within forty five (45) days of receiving the first billing statement and substantially complies with the agreement, the non-participating facility based physician may not furnish adverse information to a consumer reporting agency regarding an amount owed by the insured. For purposes of this subdivision (c)(1)(C)(v), a patient may be considered out of substantial compliance with the payment plan agreement if the payments are not made in compliance with the agreement for a period of forty five (45) days.

(3) Nothing in this subsection (c) shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit hospital insurance policies.

SECTION 3. This act shall take effect upon becoming law, the public welfare requiring it.